PSYCHOLOGICAL CARE ASSOCIATES, p.c. @ CHILDREN'S MEDICAL OFFICE of North Andover, P.C.

Confidentiality & Protected Health Information (PHI)

- **Communication between a patient and his or her psychologist, psychiatrist or counselor is confidential**, and we are bound by law and ethics to safeguard your information. We will obtain your authorization before disclosing PHI other than as described in this notice and if there is ever a breach of your child's PHI you will be notified.
- **Because PCA has joined CHILDREN'S MEDICAL OFFICE as part of your child's regular pediatric care** our psychologists' documentation of services provided will be an integrated part of the Pediatric record.
- **Professionals involved in your care** may seek consultation without further authorization to do so.
- **PCA will use and disclose the minimum information necessary** for treatment, billing, and healthcare operations involving your child's care at CHILDREN'S MEDICAL OFFICE.
- **If you use health insurance to pay for your care**, you have already given your permission to the insurance company to access information necessary to process claims, oversee services provided, and perform quality assurance functions.
- **If you are paying for care entirely out-of-pocket**, you have the right to restrict disclosure of PHI to your health plan, though this does not apply to out-of-pocket payment of health insurance co-payments or deductibles.
- **Confidentiality as it applies to minors:** Though you will be asked to be involved in and informed about your child's progress, release of specific communications often can jeopardize a child or adolescent's willingness to be forthcoming. Though the law may allow parents the right to examine treatment records, in order to both respect the confidential nature of your child's information and facilitate the building of trust, our professional staff will ask you to agree to certain limits on the information that will be shared with you. If there is ever a concern about dangerousness, you will be notified.
- **Mental health professionals are required by law to break confidentiality under certain circumstances**, including:
  - If an individual intends to take harmful or dangerous action against another individual, we must warn the person and/or family of the person who is likely to suffer the results of the harmful behavior, as well as the local authorities, in order to protect the individual and any potential victim(s).
  - If an individual poses a danger to himself or herself, we must disclose information necessary to keep the individual safe and to facilitate appropriate treatment.
  - Suspicion of child abuse or neglect and court investigations into child abuse, neglect, custody or adoption.
  - Information regarding sexual contact between children under the age of 16.
  - Suspicion of the abuse of elders or handicapped persons.
  - In response to a court order by a judge.
  - If a patient introduces his/her mental condition as an element of claim or defense in a legal or administrative proceeding.

_____ _____/_____/_____

Patient Name (Printed) Date of Birth

_____ _____/_____/_____

Patient Signature (Parent or guardian if a minor or dependent) Today's Date

_____ _____

Parent / Guardian Name (Printed) Relationship to Patient

PSYCHOLOGICAL CARE ASSOCIATES, p.c. @

PSYCHOLOGICAL CARE ASSOCIATES has entered into a partnership with **CHILDREN'S MEDICAL OFFICE** to provide Psychological Services on site, alongside, and in coordination with the Pediatricians who care for your child. Because we are a separate practice, we must ask you to review and complete these materials now, in order that you be informed about the nature and conditions of the care our Psychologists provide. Please direct any questions to your Psychologist directly.

Consent to Evaluation & Treatment

Treatment can promise great benefit and also comes with some risks. Risks can include experiencing uncomfortable levels of emotion such as sadness, guilt, anxiety or anger; and recalling and discussing unpleasant life experiences can be distressing. Prescribed medications can produce unwanted side effects in addition to the desired effects. The professionals working with you and your child will discuss with you the benefits, risks and side effects of the treatments under consideration in your child's particular case. Though there are no guarantees, the treatments we offer have been shown to benefit people and lead to reduction of symptoms, as well as improved relationships and overall ability to meet and more successfully deal with life's challenges.

In the case of minor children, parents must provide consent for treatment. In the case of shared or joint, legal custody of a child by divorced parents, the consent of one parent is required to proceed, however the other parent must not state a clear objection. If you are the parent who is bringing your child in for appointments, you will be asked for the name, address and telephone number of his or her other parent. As a routine matter, both parents will be invited to participate in your child's treatment. The exact form and frequency of such contacts will be determined on the basis of need as assessed on a case-by-case basis. Should one parent object, we cannot proceed with treatment until the objection is withdrawn or overruled on by the court. You have the right to revoke this consent at any time, in writing. Notice of revocation of consent will be considered effective on the date received.

Patient Name (Printed)	Date of Birth
Patient *Signature* (Parent or guardian if a minor or dependent)	Today's Date
Parent / Guardian Name (Printed)	Relationship to Patient

PSYCHOLOGICAL CARE ASSOCIATES, p.c. @

Authorization to communicate by e-mail

I do hereby authorize Psychological Care Associates, p.c. (PCA) to communicate with me and/or my dependent by e-mail for my own convenience, and without restriction or further qualification.

My e-mail: _____

My dependent's e-mail: _____

And / Or with: Name Relationship e-mail address

1. _____

2. _____

3. _____

Limitations:

1. I understand that e-mail is not a secure means of communication and that its use could result in an unintended breach of the confidentiality of my or my dependent's medical and/or psychological information.
2. E-mail should not be used for discussion of sensitive or private information.
3. E-mail cannot be used for urgent/emergency matters; nor can it substitute for meeting in person.
4. E-mail can be delayed, lost or intercepted, and PCA @ CHILDREN'S MEDICAL OFFICE does not use encrypted e-mail. Time-sensitive communication must be handled by telephone as the time frame within which my e-mails will be read by the intended recipient(s) is unpredictable.
5. Frequent or protracted e-mail communication is billable at our hourly rate and may not be billed to insurance.

Liability: I hereby indemnify and hold harmless, absolve and release PCA and its employees, agents, officers, directors and contractors from any and all responsibility for any breach of confidentiality or privacy that may occur, directly, indirectly or inadvertently through the use of e-mail, and I hereby waive any and all claims for liability which I might otherwise have for direct or indirect harm or damages caused by PCA's use of e-mail.

Term: This authorization will remain in effect, unless revoked, until the completion of my care at PCA.

Revocation: I understand that I have the right to revoke this authorization at any time. Should I decide to do so, I agree to provide the notice of revocation in writing. The effective date of any revocation will be that date upon which the revocation is received, processed and all affected parties notified.

_____ _____ / _____ / _____

Patient Name (Printed) Date of Birth

_____ _____

Patient *Signature* (Parent or guardian if a minor or dependent) Today's Date

_____ _____

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Billing and Payment Policies

Services provided by PCA Behavioral Health Providers are charged separately to your health plan by PCA and are subject to all the provisions of your plan's coverage of Behavioral Health Care, including separate co-payments.

You are responsible for all deductibles, co-payments and balances that are not covered by your health plan.

If you are registering a minor or dependent individual, you are accepting responsibility for his/her bills. We will not bill any other party, including a child's other parent, for services rendered or charges incurred.

All payments are due at the beginning of each visit.

We accept Cash, Personal Checks, VISA and MasterCard.

Checks should be made payable to: Psychological Care Associates, p.c. There is a **$30 charge for all returned checks.**

To bill your insurance company, we need timely, accurate information from you.

- **If your health plan denies payment,** you will be responsible for all charges if the denial is due to:
  - A lapse, termination or limitation of your coverage
  - Lack of prior authorization for which we did not have the needed information in time to secure authorization
  - Your failure to respond to your insurer's request for information from you.
- **To avoid any lapse in your care being covered,** contact our Office Manager 781.646.0500 (x112) immediately if you become aware of any problems, or if anything about your insurance changes (ex: Change of name, address, telephone number, employer, insurance company or even insurance policy with the same company.
- **Your insurance plan has limitations** on which health care services are covered, and to what extent. Excluded services include, but are not limited to: services for educational or vocational purposes; report or letter writing for any purpose beyond documentation of your care; frequent and/or lengthy telephone conversations, e-mail or other correspondence outside the treatment appointment; and any service provided outside our offices.
- **Should you request or agree to services which are not covered by your health plan**, charges are payable by you at the time services are provided.

If you become involved in a legal proceeding that requires our participation, you will be expected to pay for the Behavioral Health Professional's time, even if called to testify by another party. These fees cannot be billed to your insurance. We charge an increased hourly rate for work involving legal matters. A retainer for 5 hours service is required, renewable as needed, to cover costs, and time for preparation, communications, travel and attendance.

Release of patient information requires completion of our Authorization form**,** available from your PCA @ CHILDREN'S MEDICAL OFFICE psychologist or by contacting PCA's Patient Records Office at: 781.646.0500 x128.

Charges for reproduction of records:

- Paper copy: $25 processing fee + 25¢ per page.
- CD: $25 processing fee + $5 media charge
- Flash/Thumb Drive: $25 processing fee + $10 media charge
- Overnight letter is $25.

Our fee schedule is subject to change without notice. For current fees, contact PCA's Office Manager at 781.646.0500 x112.

Cancellations: Please give at least 24 hr. notice to avoid a $25 charge and so that the time may be used by others in need.

* Cancellation fees cannot be charged to your health insurance and must be paid prior to scheduling a future appointment.

Failure to pay bills may result in the termination of services and/or referral of the debt to a collection agency.

Your signature below indicates that you have read, understood and agreed to abide by these policies:

Patient Name (Printed)	Date of Birth
Patient ***Signature*** (Parent or guardian if a minor or dependent)	Today's Date
Parent / Guardian Name (Printed)	Relationship to Patient

Credit Card on File Agreement

I hereby authorize Psychological Care Associates, p.c. (PCA) to keep my credit or debit card information on file for payment of my charges. Payment by credit or debit card will only occur with the cardholder's agreement for each instance. Charges will not occur automatically. I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law.

If my bank or credit card information listed below changes for any reason, I will notify PCA. This authorization will remain in effect until the end date listed or until PCA has received written notification from me of its termination. In the event of returned ACH or a declined charge, my account will be charged a $30 service fee for each occurrence.

Patient Name:_____ Date of Birth:_____

Cardholder Name (as it appears on the card):_____

Cardholder Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

Card Type: American Express MasterCard Visa

Card # (Last 4 Digits only): ____ ____ ____ ____ Card Expiration Date:_____/_____/_____

Cardholder Signature:_____ Date:_____/_____/_____

PSYCHOLOGICAL CARE ASSOCIATES, p.c. @

Please complete these few questions before your visit with your Children's Medical Office Psychologist so that your time may be put to the best possible use.

Patient Name:_____ Parent Name:_____

DOB:_____ Age: _____ Grade in School: _____

What problem(s) are you are hoping to discuss?_____

How long have you been struggling with this problem?_____

How did it develop?_____

How frequently does this problem occur?	Seldom	Sometimes	Often	Always
Where does it occur (circle all that apply)?	At home	At school	With Friends	When Alone
How much distress does it usually cause you?	Mild	Moderate	Severe	

What have you already done to try to solve or deal with this problem? _____

Is a mental health professional trying to help with this problem at this time? Y N In the Past? Y N

If Yes, Who? _____

Address _____

Phone _____